STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING _____ B. WING _____	C 02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	**2640 COLD SPRING RD INDIANAPOLIS, IN 46222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00144808.

Complaint IN00144808 Unsubstantiated due to lack of evidence.

Survey dates: February 26, 27, 2014

Facility Number: 000376
Provider number: 155717
AIM number: 100275510

Survey team:
Connie Landman RN-TC

Census bed type:
SNF/NF: 36
Total: 36

Census payor type:
Medicare: 1
Medicaid: 33
Other: 2
Total: 36

Sample: 3

Alpha Home Assoc of Greater Indianapolis Inc was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00144808.

Quality Review 02/27/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.